

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OCT 07 2013

PRINTED: 09/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2013
NAME OF PROVIDER OR SUPPLIER BLUMENTHAL JEWISH NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>Submission of the response to the Statement of Deficiency by the undersigned does not constitute as admission that a deficiency exit, were correctly cited and/or require correction.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

10/5/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and physician interviews, the facility failed to submit a 24 hour and a 5 day report to the Health Care Registry for an Injury of unknown origin for 1 of 3 residents (Resident # 2) reviewed for accidents of unknown origin.</p> <p>Findings include:</p> <p>Resident # 2 was admitted on 11-27-13 with the following diagnoses: abnormality of gait localized primary osteoarthritis of left leg, moderately/severe osteopenia, left knee deformity, dementia with behaviors, lack of coordination and muscle weakness.</p> <p>A record review of the Minimum Data Set (MDS) dated 6-1-13 revealed the resident was not interviewable and a BIMS (Brief Interview for Mental Status) score was unable to be obtained due to her dementia status. The resident required extensive assistance with bed mobility and transfers but could propel self throughout the facility using her feet to paddle her wheelchair.</p> <p>A record review of the care plan dated 6-10-13 addressed the potential for alteration in comfort related to end stage osteoarthritis of the left knee. Further review revealed the resident as a falls risk. The resident was assessed as being a stand and pivot transfer due to her fear of falls. Resident # 2 would become extremely agitated and combative when a lift was used, therefore creating a greater risk of injury.</p> <p>A record review of the nurse 's notes dated 8-15-13 revealed the resident was found by NA #</p>	F 225	<p>Resident #2 is no longer a resident in the facility</p> <p>All residents have the potential to be effected by this allege deficient practice. Recently & previous facility investigations have been audited by the Administrator and Director of nursing to ensure that investigations were reported and investigated within the State and Federal Regulations</p>	<p>8/15/13</p> <p>9/30/13</p>	

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F 225	<p>Continued From page 2</p> <p>1 attempting to get in her bed and asked the resident if she needed help. The resident told the NA that her ankle hurt. NA #2 entered the room to assist NA # 1 to stand and pivot the resident to the bed. The nurse assessed the ankle after the resident was lying in the bed and noted there was "movement above the ankle where there shouldn't be". Per the record, the physician was notified at that time and an order was received to obtain a mobile x-ray at the facility.</p> <p>A review was conducted of the mobile x-ray report, dated 8-16-13 which confirmed a spiral fracture to the tibia/fibula.</p> <p>Further review of the nurses notes dated 8-16-13 revealed the nurse contacted the physician with the mobile x-ray results. At that time an order was received to transport the resident to the hospital for further treatment</p> <p>An interview was conducted on 9-10-13 at 5:00pm with NA # 3 who was present at the time the swelling and bruising to the left ankle was noted. She stated the resident was found attempting to put herself in bed. NA #1 and NA # 2 assisted the resident to the bed and it was at this time the resident cried out in pain and indicated that there was pain in the left ankle. NA # 3 stated the resident was a two person assist to pivot/transfer due to her fear of falling from the lift.</p> <p>An interview was conducted on 9-11-13 at 2:10 pm with the Registered Nurse (RN) assigned to Resident #2 on 8-15-13. She reported that she had witnessed the resident up at the dining room table eating her meal independently at 6:30 pm. The resident showed no indications of pain or</p>	F 225	<p>Administrator received re- education</p> <p>Regarding the reporting requirements of injury of unknown origin by the Regional Director of Operations.</p> <p>Administrator will provide re-education for the facility staff to include administrative, nursing and ancillary staff related to reporting injury of unknown origin and, reporting an intent F-225.</p>	<p>9/26/13</p> <p>10/5/13</p>	

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F 225	<p>Continued From page 3</p> <p>discomfort at that time. The RN reported that she had taken her evening break and when she returned around 7:00 pm, NA # 1 asked her to come to Resident #2 room. The nurse stated she assessed the residents' foot and noted the foot was " Obviously broken. " The RN reported she notified the physician at that time who ordered a mobile x-ray to be done in the facility.</p> <p>During an interview on 9-11-13 at 2:50 pm with NA # 1 who was assigned to Resident #2 on 8-15-13, it was revealed NA # 1 was passing the residents room and noticed the resident attempting to get into bed by herself. NA # 1 stated that she asked the resident if she was ready to go to bed and the resident replied that she was because her ankle was hurting. At this time, NA # 1 stated that she asked NA # 2 and NA #3 who were passing in the hall to assist her to put Resident #2 to bed. She stated the resident complained of pain and cried out during the stand/pivot transfer. NA # 1 stated she heard no popping noises indicating the fracture could have occurred during the transfer. It was during the time that NA # 1 and NA #2 were pulling on the resident's gown that the swelling and bruising was noted.</p> <p>An interview was conducted with NA # 2 on 9-11-13 at 3:30 pm. She reported that she assisted NA # 1 to put the resident to bed and that the resident only complained when they attempted to stand her up. NA # 2 denied hearing any popping noises during the transfer, indicating that the resident may have been injured during the transfer. NA # 2 stated that she noticed the swelling and bruising to the left ankle when she placed the resident on the bed.</p>	F 225	<p>Incident / Accidents, concerns and</p> <p>24 hour reporting will be</p> <p>reviewed Monday – Friday daily at</p> <p>the facility daily meetings by the</p> <p>DON and Administrator to ensure</p> <p>that any issues of injury of unknown</p> <p>origin are identified, investigated</p> <p>and reported timely.</p>		

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F 225	<p>Continued From page 4</p> <p>On 9-11-13 at 4:10 pm, an interview was conducted with the Administrator. She reported that she did not investigate this fracture as an injury of unknown origin and did not submit a 24 hour or 5 day report to the Health Care Registry because the physician deemed the incident as a pathological fracture related to diffuse, severe to moderate osteopenia. The Administrator followed the facility policy with an in house investigation which involved interviewing all staff involved. Staff to resident abuse was ruled out.</p> <p>An interview was conducted on 9-12-13 at 8:45 am with Resident #2 physician. The physician came to the facility to explain that the fracture the resident received was pathological related to her past history of severe osteopenia. He stated the fracture could have possibly occurred while the resident was self propelling herself using her feet to peddle herself along in the hall. He stated that injury did not always have to occur to cause a pathological fracture and the resident may not have experienced acute pain until she was assisted up and pivoted to the bed by the staff. At this point, the physician stated the resident may have yelled out in pain. The physician stated "The nature of a spiral fracture is depending on the movement of the bone when the pathological fracture occurs."</p>	F 225	<p>Administrator will review weekly results to analyse for any trends and report findings monthly for 3 months to the facility QA committee. The QA committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance.</p> <p>Monitoring will be monthly times 3 months then quarterly for one year by Administrator and/or designee</p>		